Office of the Child Advocate

Compilation of Delaware's
Child Protection Issues and Recommendations from
Child Abuse/Neglect Death and Near Death Case Reviews

March 17, 1997 to May 5, 2006

Second Edition

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No documented public recommendations at this time.

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DIVISION OF FAMILY SERVICES 16 Del.C. § 912 (b) (1)

OFFICE OF CHILD CARE LICENSING

1. Criminal background checks were not being done on prospective adoptive parents who lived with a biological parent.	Delacare Regulations are currently under revision through the Child Placing Agency Rule Revision Task Force. Since this process is lengthy, the Commission recommends that Child Placing Agencies are noticed that it is best practice to conduct criminal background and child protection registry checks on all perspective adoptive parents prior to finalization of an adoption. It is recommended that these agencies are encouraged to immediately begin conducting such background checks, pending rule revision.	**DSCYF response:** **In process** *Rule revision is in process for Requirements covering Child Placing Agencies. The Task Force reconvened and this issue was addressed.* *Child Placing Agencies are now being advised that it is a best practice to conduct background checks on all perspective adoptive parents prior to finalization. CPAs are conducting checks prior to the completion of a home study.*	Child Death Near Death Stillbirth Commission (CDNDSC) Expedited Review, letter to the Governor 4/19/05.
2. Caseloads too high.	It is recommended that the Department of Services for Children, Youth and Their Families review the caseloads and responsibilities of Office of Child Care Licensing (OCCL) and submit caseload and resource proposals for improving compliance with this area of regulation in accordance with the above recommendations. 29 Del. C. § 9015(b)(5) requires an adequate number of licensing specialists for child care centers and family child care homes so that caseloads do not exceed 150 per specialist.	**DSCYF response:** **In process** *All functions of the Licensing Specialist are being identified, quantified. This "item" is also related to the recommendation of a "complaint investigative" structure as this function is currently being fulfilled by Licensing Specialists as part of their general duties.*	CDNDSC Expedited Review, letter to the Governor 12/9/04.

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3. Delaware citizens should easily be able to obtain access to information regarding licensed child care, including access to history of substantiated complaints of abuse and/or neglect against a particular employee, home and/or center. The Department of Services for Children, Youth and Their Families, Division of Family Services, Office of Child Care Licensing is the State entity charged with licensing child care, investigating violations, and maintaining information regarding complaints against day care facilities and employees in Delaware. 31 Del. C., Ch. 3, Subch. III.	Current practice requires a citizen to schedule an appointment with the Office of Child Care Licensing ("OCCL") at which time they must be physically present to review the OCCL file pertaining to a particular child care provider. The intent of Delaware's Parents Right to Know Act (31 Del. C. § 398) is to increase a parent's access to information about licensed child care facilities. OCCL should develop a comprehensive database on all licensed child care homes and centers, including enforcement actions and substantiated complaints. This information needs to be easily accessed via the Internet, telephone and in person. The Commission also notes that the Parents Right to Know Act requires OCCL to make certain child care information, including enforcement actions, available on the website of the Department of Services for Children, Youth, and their Families. Enforcement actions do not appear to be available online. The Commission recommends that OCCL come into compliance with and review the scope of the Act's mandate.	**DSCYF response:** **In place; enhancements in process** *A comprehensive database exists and contains the recommended information. It is from this database that is the source of information placed on the website.* *Information pertaining to enforcement actions taken on child care providers is currently available on the OCCL page on the DSCYF website. It is not user friendly and OCCL is currently in consultation to improve this.* *Telephone requests for information are responded to by Licensing Specialists.* *The on-site record review process is still in place.*	CDNDSC Expedited Review, letter to the Governor 12/9/04.
4. Regulations regarding family child care homes need to be updated to meet best practice.	Specifically, the items listed below should be reviewed: a.) Completion of comprehensive safety assessments for all licensed child care providers placed on the Child Protection Registry prior to February 1, 2003. Assessments should	**DSCYF response:** **In process** *Update: Rule revision is still in process for child care centers. A second draft will be presented for public comment in Spring 2006.* *Family and Large Family child care regulations review process has been initiated. These issues will be addressed during that process.* *DELACARE regulations govern the operation of child care in Delaware, and are promulgated and*	CDNDSC Expedited Review, letter to the Governor 12/9/04.

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	include but not be limited to a review of the provider's DSCYF history, progress on any corrective action plans entered by OCCL, and unannounced home inspections. *See #3a below for further details;* b.) Use of substitute caregivers; c.) 24-hour care; d.) Safe infant sleeping practices; e.) Mandated time frames for center/family child care home inspections keyed to licensure renewal; f.) Institution of a quality assurance mechanism to ensure that regulations and procedures established to protect children in child care settings are followed; and g.) Education on and appropriate application of 16 Del. C., Ch. 9, Subch. II (§§ 921-929) (Child Protection Registry) by OCCL regarding the operation of family child care homes and persons working in centers.	*overseen by the Department of Services for Children, Youth and Their Families, Division of Family Services, Office of Child Care Licensing. DELACARE regulations pertaining to family child care homes were last updated in 1993. Current proposed changes to the regulations only focus on child care centers (Proposed Rules for Early Care and Education and School Age Centers).*	
5. Investigation of child care providers.	General Policy Recommendations for Department of Services for Children, Youth and Their Families, Division of Family Services, Office of Child Care Licensing Therefore, the Commission recommends the following changes in policy and practice: a.) Senate Amendment 1 to House Bill 528 prohibited the retroactive termination of employment for child care providers who had a substantiated history of abuse and/or neglect. As a result, an	**DSCYF response:** ***Completed*** *A crosswalk of child care providers and Registry findings was completed in December 2004. Each individual was reviewed by Licensing staff.* *a. This issue has been discussed with the Office of the Attorney General. It was their opinion that the OCCL could not enforce the requirements under HB 528 against those individuals that were substantiated prior to enactment of that legislation.* *For all of those cases that occurred prior to the enactment OCCL took appropriate actions.* *b)* **In place** *An internal review occurs to assess the circumstances of each situation of a complaint/violation/abuse allegation that includes the OCCL Administrator. Recommendations are made for any corrective action plan or other action. CQI is under development.*	CDNDSC Expedited Review, letter to the Governor 12/9/04.

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	undetermined number of family child care homes continue to operate despite the placement of employees/operators at Level III or IV of the Child Protection Registry. It is imperative that OCCL complete comprehensive, timely safety assessments for all licensed daycare providers placed on the Child Protection Registry prior to February 1, 2003. This assessment should include but not be limited to a review of the provider's DSCYF history, progress on any corrective action plans entered, and home inspections to ensure that safety exists in those homes. b.) Quality assurance mechanisms should be implemented to ensure that regulations and procedures established to protect children in child care settings are consistently applied and followed, and that corrective action plans are formally implemented. c.) Create an independent investigative unit within the Department to thoroughly investigate DELACARE requirement violation complaints similar to the procedure for investigation of institutional abuse/neglect complaints. Investigation of DELACARE requirement violations and institutional abuse/neglect complaints should utilize all available investigative resources,	*c)* **In process** *The feasibility of implementing this recommendation is being reviewed as part of the caseload monitoring and review of caseloads and responsibilities (see item two) process.* *Whenever there is a complaint Licensing Specialists currently utilize all available investigative resources to further the investigation.* *d)* **In place** *Time frames have been implemented. A monthly monitoring report provides supervisors and the administrator the status of complaints assigned to each Licensing Specialist.*	

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	including but not limited to the Children's Advocacy Center, DSCYF history and, in the case of abuse and neglect complaints, criminal history as well. d.) Policies and procedures should require that responses to reported child care complaints are timely, consistent, and include a uniform reporting mechanism. A specific time frame in which the investigation will occur and close supervision of the process to ensure compliance should be implemented. Deficiencies should be addressed through a specific corrective action plan with timeframes and follow-up.		
6. SIDS (Sudden Infant Death Syndrome) education and safe sleeping practice education.	Provide ongoing education to licensed daycare providers, recognizing that this does not address unlicensed day care providers. SIDS education to be included as a mandatory component of basic preparation for licensure as a daycare provider. Educational materials already available and it is recommended that the Children's Department collaborate with the perinatal association for these materials.	**DSCYF response:** **In place** *Update: Information on infant sleeping positions recommended by the American Academy of Pediatrics is distributed to all applicants for child care licenses at orientation.* *Three years ago, the Office of Child Care Licensing did a mass mailing to all licensed providers on the "back to sleep campaign". The Office of the Child Care Licensing is currently working on a core curriculum regarding "back to sleep" recommendations that will be part of their Mandatory First Aid/CPR training. All new daycare center regulations have this education as part of their procedures. The Delacare regulations governing licensed daycares need to be clear about safe sleeping practices. The perinatal association is now defunct.*	CDNDSC Annual Report 2001/02
7. Unlicensed daycares.	A fine should be imposed on individuals running an unlicensed daycare. This fine could be consistent with other fines given when operating licenses are required	**CDNDSC Annual Report:** *This has been in Delaware Code since 1915 but has never been utilized.*	CDNDSC Annual Report 2001/02
8. Hiring criteria/screening for childcare positions.	The Division should establish better screening criteria and standards for hiring workers for child care positions.	**DSCYF response:** **In place** ***The Department plays no role in the actual hiring of workers by private providers.*** ***As a result of this recommendation, l****egislation was passed in 1997 which required child and medical care providers to check the criminal and child abuse histories of potential employees, but that legislation left the hiring decision to the employer. Several years later, in response the*	Bryan Martin Independent Review Panel 3/17/1997

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		Department's efforts to introduce due process to the Registry, a legislative committee's efforts resulted in amendments that included prohibitions on hiring of individuals for certain civil substantiations. *In addition, the Child Care Licensing Regulations outline education and training requirements for day care workers*	
9. Hiring criteria/screening for childcare positions.	A policy should be implemented to prohibit hiring by childcare centers of individuals with a cumulative history of substantiated complaints. The Division should develop a registry of such individuals.	**DSCYF response:** **In place** *See above*	Bryan Martin Independent Review Panel 3/17/1997
10. FACTS computer data check	FACTS should include a means to obtain all data by reference to the perpetrator, especially in the Office of Child Care Licensing records.	**DSCYF response:** **In place** *The hotline search was enhanced to allow the workers to gather information about all cases pertaining to the person being reviewed. This includes Institutional Abuse records. Training was provided to both OCCL and OCS staff on this function.*	Bryan Martin Independent Review Panel 3/17/1997
11. Child who was physically abused did not have a current physical. The family care physician is often seen as a safety net to report concerns of abuse/neglect.	Children enrolled in child care centers without current physical examinations should be reportable to DFS by providers.	**DSCYF response:** *Not adopted: **51**,000 children in paid childcare.*	Bryan Martin Independent Review Panel 3/17/1997

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CASELOADS/WORKLOADS

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1. Caseload/workload	DFS should manage caseload distribution so that cases with a chronic risk of recurring abuse/neglect/dependency and/or presenting with multiple complicating factors are counted, or weighted to reflect their complexity. This theoretically would allow case managers more time to devote to the family who presents with more intensive needs.		CDNDSC Expedited Review, letter to the Governor 3/31/06. (different case but same recommendation as listed below)
2. Caseload/workload	DFS should manage caseload distribution so that cases with a chronic risk of recurring abuse/neglect/dependency and/or presenting with multiple complicating factors are counted, or weighted to reflect their complexity. This theoretically would allow case managers more time to devote to the family who presents with more intensive needs.		CDNDSC Expedited Review, letter to the Governor 3/31/06.
3. Over hire positions being filled	The Division should immediately fill all 15 over hire ("trainee") positions and keep those positions filled pursuant to 29 Del. C. § 9015(b) (4) so that fully trained staff are always available to fill vacancies**.** While the Department has indicated that filling the over hire positions will not alleviate the high caseloads that they experience on a regular basis, the Subcommittee believes that a commitment to use of the over hire positions will assist in providing the needed resources when dealing with positions of high-turnover and burnout.	**DSCYF response:** **In place** *DSCYF had already been reporting over-hire details to CPAC on a quarterly basis (filled and vacant).*	CPAC near death report on John Davis, Jr. released 5/4/05
4. Caseload/workload	Caseloads must be at or below the standard set for each worker. If not, CPAC should be alerted.	**DSCYF response:** **In place** *As required by S.B. 142 and S.B. 265 we have been reporting comprehensive caseload information to the legislature and CPAC.*	CPAC near death report on John Davis, Jr. released 5/4/05
5. Caseload/workload	DFS should commence a comprehensive work study analysis to identify barriers to quality social work and provide short and long term solutions for a manageable workload for DFS social workers**.**	**DSCYF response:** **In process** *See two items above*	CPAC near death report on John Davis, Jr. released 5/4/05

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6. Caseload/workload	DFS caseworker's caseloads should be reduced, through an increase in the number of workers and the implementation of steps designed to reduce staff turnover.	**DSCYF response:** **In place** *See items above* *Background: In addition to creating legislatively mandated caseload standards, the Department received authority to fill 15 DFS trainee and several casual/seasonal positions. Retention initiatives included a career ladder. As a result, caseloads and turnover were significantly reduced and stabilized.*	Tytyana Kennedy Independent Death Review 4/22/98

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CASEWORK

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1. Lack of comprehensive assessment of the needs of the family.	DFS should review current practice and policy with regard to case planning to ensure services are meeting the identified need (s) and are monitored to measure progress and influence case decisions.		CDNDSC Expedited Review, letter to the Governor 3/31/06.
2. Lack of comprehensive assessment of the needs of the family.	DFS should explore ways to access experts that can provide consultation on issues like substance abuse, mental health, and domestic violence. These experts must be available to all DFS staff and DFS must have adequate time to consult these experts during an investigation. These experts give valuable information regarding the parent's ability to keep the children safe.		CDNDSC Expedited Review, letter to the Governor 3/31/06.
3. FACTS computer search	DFS caseworkers need a user-friendly process, including automated computer access, to identify and link cases where a single person may be involved with more than one family. The current participant listing search process may be cumbersome and difficult to navigate for caseworkers.	**DSCYF response:** **In process** *Proposed changes are being included in FACTS II requirements/ development project.*	CDNDSC Expedited Review, letter to the Governor 4/19/05.
4. Cases frequently reopened. Cases closed before risk factors resolved.	Case review indicated that there were instances when cases were prematurely closed before risk factors were completely resolved. Reviewers in one site examined several cases that had been closed and reopened for service, several times for the same general concerns	**DSCYF response:** **In place** *Case closure policy was revised to include additional steps workers and supervisors should take before closing a case. Also, case closure guidelines were developed to be used by supervisors and workers. The Department submitted a Program Improvement Plan which DHHS approved and from which DHSS has since released DE for compliance.*	Children and Family Services Review (CFSR) Final Assessment, June 22, 2001 U.S. Dept. of Health and Human Services.
5. Lack of cooperation from parents	Case reviews identified that some parents were uncooperative and cases were closed even if risk factors continued. Stakeholder interviews explained that if families chose not to cooperate, and the situation did not rise to the level that required removal of the children, then the case was closed despite ongoing risk factors and a lack of progress toward case goals.	**DSCYF response:** **In place** *Case closure policy was revised to include additional steps workers and supervisors should take before closing a case. Additionally, case closure guidelines were developed to be used by supervisors and workers. Refresher Engagement training provided in 2003 – specifically targeted uncooperative parents and those where communication otherwise proved challenging. Also covered in new worker core (102): Interviewing.*	CFSR June 22, 2001

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6. Lack of DV (domestic violence) training and knowledge	Staff seemed to lack recognition of the relationship between domestic violence and child abuse and/or neglect. The failure of agency staff to address the domestic violence conditions of some families was found in the case reviews.	**DSCYF response:** **In place** *Each region now has a domestic violence liaison co-located. The Liaison receives cases at the point the hotline report is reviewed and they are able to provide services to the family through treatment and even after the DFS case has been closed. In addition to the work the liaisons are doing with the family, they are also available to staff for consultation. They provide regular brown bag seminars for staff including such topics as how to file a PFA. All staff, regardless of the programs they work in, has access to the DV liaisons.* *A Domestic Violence Advocate Pilot Project was implemented in January 2002 whereby advocates from private agencies are collocated in DFS regional offices to assess and provide services to adult victims of DV. The project began in Sussex and expanded to all regional offices.* *Training has been expanded:* ▪ *(102B)Domestic violence from 1 to 2 and now to 3 days*	CFSR June 22, 2001
7. Lack of comprehensive assessment of the needs of the family.	The review found that there was a lack of comprehensive assessments for children and families being served by the agency. This lack of assessment contributed to the lack of appropriate services to meet children's and parent's needs, which often resulted in cases being closed without the provision of necessary services. Over half of the cases examined in one county demonstrated this problem. 25% of the cases in another site and 18% of the cases reviewed in the third site did not have comprehensive assessments.	**DSCYF response:** **In place** *In 2001, DFS replaced the diagnostic profile with the Family Assessment Form (FAF). The FAF provides a more comprehensive family assessment. Treatment staff also began completing a Safety Assessment at their first face to face contact; any time there was a significant change in the family, prior to reunification, and prior to closing a case. In 2003, the Department implemented the Service Entry Needs and Strengths Screen (SENSS). The SENSS provides an assessment of all children residing in their own home. For children in out-of-home care – their needs are assessed in the Plan for Child in Care series.* *A Domestic Violence Advocate Pilot Project was implemented in January 2002 whereby advocates from private agencies are collocated in DFS regional offices to assess and provide services to adult victims of DV. The project began in Sussex and expanded to all regional offices.*	CFSR June 22, 2001
8. Training and child safety	Emphasis on child safety in training and supervision. Whatever focus DFS is currently placing upon child safety in the training and supervision of its caseworkers is apparently insufficient. We have not had the opportunity to review the Division's training program in detail, but that program should be reviewed by someone outside the Division and modified where necessary to appropriately emphasize child safety.	**DSCYF response:** **In place** *Action for Children was engaged. "Initial safety assessment and safety plan" policy was effective 8/1/1998. All investigation staff were trained in June 1998. The safety assessment was revised in 2001 and all staff participated in training.* *Child safety is incorporated in all relevant core training, refresher training and TOL (Transfer Of Learning) manuals.*	Dejah Foraker Independent Review Panel 1/8/1999
9. One case/one worker	We believe that the Division should implement a system whereby the worker who initially	**DSCYF response:** **Not a best practice at that time or currently**	Dejah Foraker, Independent

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	investigates a case is the same worker who monitors the case throughout the Division's involvement. There is no real substitute for the cumulative first-hand impressions that a worker gains as he or she sees a family in its time of crisis and as it attempts to resolve its problem.	*Investigation function should be independent of treatment services. The Division is pursuing other workload assignment strategies to be reported in the near future.*	Review Panel Report 1/8/1999
10. FACTS data entry	Staff should be required to enter data into the system immediately.	**DSCYF response:** **In place** *all info is to be entered into FACTS within 48 hours.*	Bryan Martin Independent Death Review 3/17/97
11. Responses to difficult complex cases.	The Division should establish an interdisciplinary case review mechanism for difficult complex cases. This oversight body would ensure greater coordination among all involved workers and supervisors and should improve the responsiveness and effectiveness of the Division's actions. The Panel further believes that the Division's goal should be to create an atmosphere of Continuous Quality Improvement (C.Q.I) throughout the Department, with emphasis on peer supervisory collaboration, which would thereby reduce variability in the criteria used to substantiate investigations.	**DSCYF response:** **In place and in process** *The Department has implemented several initiatives to address better coordination among all service providers, both within and outside the Department, most recently positioning the department and partners to take full advantage of the System of Care approach, a nest practice proven to be more effective in complex cases..* *CQI is also well underway, from constant random reviews, structured root cause analysis and participation in CDNDSC reviews, as well as federal and accreditation reviews.*	Bryan Martin Independent Death Review 3/17/97
12. Incident based thinking.	Another theme throughout this process has been the Panel's concern about the Division decision-making with regard to a child at risk in his own home. It appears that the Division was waiting for a specific incident of serious risk to remove the child from his home, when ongoing victimization can be even more damaging than a severe single incident. Documented patterns of abuse or neglect may warrant removal even in the absence of a single serious incident.	**DSCYF response:** **In place** *A SENSS is completed on every child residing in their own home. In addition, staff was provided a refresher training focusing on assessing risk, taking into account the family's previous history with the DFS or the Department.* *Core training emphasizes the need to assess the entire risk; meaning the incident in conjunction with criminal record, family structure and all identifiable history. Decision making, as trained, is to be based on the entire picture assembled, not a specific reported incident.* *Supervisors now routinely complete directed case conferences which focus on accumulation of risk and ongoing safety concerns as well as evaluating the effectiveness of case plans.*	Bryan Martin Independent Death Review 3/17/97
13. FACTS policies	The Division should develop appropriate policies to deal with computer "down time".	**DSCYF response:** **In place** *Backup databases have been created.*	Bryan Martin Independent Death Review Panel 3/17/1997
14. Training	Comprehensive relevant training of all Division	**DSCYF response:**	Bryan Martin

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	staff should be mandated, and training should be completed by all new workers prior to assignment to any investigation. Training should also be targeted to the specific skill area (e.g., hot line, urgent response treatment) to which a particular worker will be assigned.	**In place** *No caseworker receives full responsibility for any case until they have received basic core training. This includes permanent caseworkers, over-hire staff and casual/seasonal staff.* *All staff are required to complete Phase I and Phase II training within the first 2 years of employment. Thereafter, they are required to complete 18 hours of specialized training per year.* *Workers receive ongoing training and coaching in specific skill areas from supervisors.* *The Department provides supervisory training which includes a System of Care focus, and DFS complements that with specialized supervisory training. DFS requires an additional customized two-day training session.* *Supervisors participate in all refresher trainings. Components, specifically for supervisors, have been incorporated into several refresher trainings. The Office of the Child Advocate has been highly complimentary of our actions in this area.*	Independent Death Review Panel 3/17/1997
15. Training	Staff who "volunteer" without specialized training in identifying risk factors and physical signs of abuse and neglect should not be responsible for hot line or urgent response functions.	**DSCYF response:** **In place** *See above*	Bryan Martin Independent Death Review Panel 3/17/1997
16. Training	"Casual and seasonal" (temporary) employees should be required to undergo the same in-depth comprehensive training now required of all new workers.	**DSCYF response:** **In place** *See above*	Bryan Martin Independent Death Review Panel 3/17/1997
17. Training	Training should continue during the course of an individual's employment. Supervisory personnel should be required to undergo specialized refresher training, rather than rely exclusively on their years of experience as a criterion for assuming a supervisory role.	**DSCYF response:** **In place** *See above*	Bryan Martin Independent Death Review Panel 3/17/1997
18. Training	Training should be improved in the areas of child development and identifying and interviewing non-verbal or unresponsive children.	**DSCYF response:** **In place** *All caseworker staff receive comprehensive training in child development, including:* - *Physical, social, emotional, cognitive signs of appropriate development* - *Early warning signs of developmental delays and disabilities* - *Age appropriate behaviors* - *Identifying the detrimental effects of child abuse/neglect* *Training includes interviewing techniques focusing on the age, developmental stage of the child, and their linguistic capacity. It is not specific to children who present as non-verbal and unresponsive because of some existing pathology.* **In process** *The Children's Advocacy Center in collaboration with DFS, Police, AG's office, and OCA will be*	Bryan Martin Independent Death Review Panel 3/17/1997

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		bringing "Finding Words" training to Delaware.	
19. Training	The Bryan Martin case should be incorporated as a case study in the curriculum for training all new personnel.	**DSCYF response:** **In place**	Bryan Martin Independent Review Panel 3/17/1997

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HIRING PRACTICES AND SUPERVISION ISSUES

20. Supervision	DFS workers need to be closely monitored to ensure that they are adequately performing their job. Mistakes, poor judgment, lack of knowledge and differing philosophies by workers can cost children their lives. Supervisors who cannot adequately monitor and supervise their subordinates' work should not be in the role of a supervisor.	**DSCYF response:** **In place** *Individual performance is managed through structured performance review process and, as needed, around particular events.* *The Department recognizes that a performance error may have ramifications in other cases and takes steps to ensure the safety of children.*	CPAC near death report on John Davis, Jr. released 5/4/05
21. Quality assurance/personnel issue	DFS Management should perform reviews of other cases handled by investigation worker #1 and treatment worker #2 to ensure that decisions were not and are not being made that leave children at grave risk of abuse, neglect and possibly death.	**DSCYF response:** **In place** *See above*	CPAC near death report on John Davis, Jr. released 5/4/05
22. Supervision	Each supervisor should briefly consult with each worker daily on pending cases.	**DSCYF response:** **In place** *Worker/supervisor case conferences review critical data elements at regularly scheduled intervals, which vary with the intensity of the case.*	Dejah Foraker, Independent Review Panel Report 1/8/1999
23. Supervision	Individual worker/supervisor case review conferences should be held weekly. Supervisor/staff case discussions should be held regularly.	**DSCYF response:** **In place** *See above*	Dejah Foraker, Independent Review Panel Report 1/8/1999

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INVESTIGATION

1. Collateral contacts	DFS should explore what information can be legally obtained and legally shared with other professionals working with the family so that they can determine the most appropriate intervention for the family. Collateral collaboration needs to be improved.		CDNDSC Expedited Review, letter to the Governor 3/31/06.
2. Risk Assessment tool	In the short term, DFS should reiterate the importance of the current risk assessment tool and ensure that workers are using it. Clearly there is a disconnect for some between policy and practice regarding the Risk Assessment Tool. Policy states this tool is important and should be used by workers in decision making, yet one worker and supervisor say it is useless and largely ignored.	**DSCYF response:** **In place** The risk assessment tool is mandatory for completing investigation cases. While individuals may not agree with the policy requirement, the FACTS system design is such that a worker cannot continue the casework without completing the risk assessment tool.	CPAC near death report on John Davis, Jr. released 5/4/05
3. Initial contacts during investigation Compelling uncooperative parents.	DFS should require an actual meeting, not a diligent attempt to make one, to occur within the DFS investigation guidelines. After one contact is missed and the time deadline for making the contact has passed, a plan should be developed by the DFS regional administrator for ensuring that prompt contact with the family and children is made. If statutory changes are needed to provide workers with additional tools to compel parents whose cases are opened with DFS to cooperate, that issue should be brought to light. Most important, workers must recognize that a parent's failure to meet with DFS may be a warning sign that the parent is attempting to conceal abuse by evading authorities.	**DSCYF response:** **In place** *DFS has had Client Lack of Cooperation policy since May 1997. The policy stipulates timeframes for visiting non-cooperative clients (urgent and routine reports) and includes having a Deputy Attorney General write a letter to the clients. DFS has the ability to file a Petition to Compel Cooperation, but the focus is to compel the parents to give DFS access to interview the child. DFS does not have the legal authority to compel a parent to cooperate with an investigation.* *This matter has been advanced and opposed more than once in recent years.*	CPAC near death report on John Davis, Jr. released 5/4/05
4. AOD screening tool.	Five years ago, the Children's Dept. implemented a drug and alcohol screening tool for use in child	**DSCYF response:** **In place; in process**	CDNDSC Expedited

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Risk Assessment instrument	abuse investigations in response to an Independent Review of a child death. The Dept. has since been utilizing this tool, and is currently reviewing the screening instrument for validity. The Commission supports the Department's efforts to revisit the utilization of the current screening instrument. The Commission recommends the Department research the use of newer empirically valid screening instruments, and/or drug/alcohol abuse screening tools recommended by the Child Welfare League of America or other nationally recognized child welfare agencies.	*A comprehensive review of the Risk Assessment Tool was completed and the agency determined that changes would occur with the new FACTS II effort.*	Review, letter to the Governor 4/04/05.
5. Domestic Violence	DFS should include screening questions on domestic violence in all of their investigations.	**DSCYF response:** **In place** *It has been the policy of DFS since the summer of 1998 to screen for domestic violence during each investigation. DFS inquires about the presence of DV when taking a report. The initial screening occurs during the safety assessment.*	Fatal Incident Review Team (FIRT) Annual Report 2003
6. Domestic Violence	DFS should work with representatives of the Advocacy Community in developing a protocol for responding to domestic violence cases.	**DSCYF response:** **In place** *In January 2002, DFS and Families in Transition implemented a collaborative pilot project that co-located a domestic violence advocate from FIT with DFS in Georgetown. Since then the project has expanded to New Castle (October 2002) and Kent (December 2003)*	FIRT Annual Report 2003
7. Interviewing	It is recommended that DFS adhere to their policy to interview all family members separately.	**DSCYF response:** **In place** *Individual performance is managed through structured performance review process and, as needed, around particular events.*	FIRT Annual Report 2003
8. Collateral contacts	Require child abuse investigators to routinely contact primary care physicians to assess prior care and risks for future abuse of other children	**DSCYF response:** **This recommendation was directed at other child welfare partners who investigate child abuse.** *Our policies are consistent with this recommendation.*	CDNDSC Expedited Review, letter to the Governor 10/23/02.
9. Abridged cases.	In some cases analyzed, not all issues on the risk assessment forms were completed or assessed.	**DSCYF response:** **In place** *When a case is abridged, the worker is not required to complete all the force fields on the risk assessment form because risk assessment is completed at initial case.*	CFSR June 22, 2001
10. Risk not assessed properly, not appropriate services provided.	The findings of the review indicated a lack of assessments of risk in several cases that resulted in appropriate services not being provided to reduce the risk of harm.	**DSCYF response:** **In place** *Policies and procedures are in place to conduct thorough risk assessments. Quality case reviews help ensure that policies and procedures are followed.*	CFSR June 22, 2001
11. Transfer of information	Improved transfer of information. The division should at least ensure that workers who are transferring cases have a face-to-face meeting with the worker who will be taking over the case,	**DSCYF response:** **In place** *first responder must personally (not necessarily face-to-face) discuss case with the assigned investigation worker. This is monitored.*	Dejah Foraker, Independent Review Panel Report

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	along with the new worker's supervisor, to ensure that the new worker knows everything he or she needs to know about the child and the family.		1/8/1999
12. Safety plans	DFS should prepare written safety plans for parents under investigation by the Division, and those safety plans should be signed by parents at a face-to-face meeting within three days after a child's injuries are first observed. DFS should verify compliance with these safety plans within three days after they are signed, and on an ongoing basis.	**DSCYF response:** **In place** *Safety assessment is required for all initial interviews and if a plan is indicated, is done at first contact. A new safety assessment is done when the case is transferred to treatment. A signature is sought, but a parent who does not sign must still comply with the plan.*	Tytyana Kennedy Independent Death Review Panel 4/22/1998
13. Transfer of information/collaboration	DFS and law enforcement agencies should take steps to ensure that investigators who respond to weekend or evening calls remain personally involved in the cases that they open.	**DSCYF response:** **Not a best practice** *While DFS after **hours** staff are responsible for immediate contact with day time staff, they do not remain involved in the case.*	Tytyana Kennedy Independent Death Review Panel 4/22/1998
14. Subpoena power	The Division should be given limited subpoena power, to improve its investigative capabilities and reduce wasted staff time. The Division should also take steps to more quickly identify those cases that are not truly urgent.	**DSCYF response:** **In place***: Legislation was passed which allows us to petition the Family Court for a motion to compel cooperation in investigation.*	Tytyana Kennedy Independent Death Review Panel 4/22/1998
15. Risk assessment tool	The Risk Assessment instrument should distinguish biological parents and related individuals from unrelated caregivers.	**DSCYF response:** **In place***: Policies were revised to require all adults residing in the household with care taking responsibilities for the children to be interviewed and individually assessed for risk to the children. FACTS participant groups enable the distinguishing of caretaker vs. non-caretaker.*	Bryan Martin Independent Death Review 3/17/97
16. Incident based thinking Risk assessment tool	FACTS should be redesigned or refined to produce warning signals based upon cumulative evidence of abuse rather than focused exclusively upon specific defined "events" that have definitive beginning and ending points.	**DSCYF response:** **In place** *FACTS now shows number of danger loaded elements in the subject line of the investigation events. History is included. See later related items.*	Bryan Martin Independent Review Panel 3/17/1997
17. Risk assessment tool	Policy and training should emphasize that the goal of FACTS and its Risk Assessment tool should not be to complete the report deadlines but to determine acceptable versus unacceptable levels of risk.	**DSCYF response:** **In place***: Policy revisions and corresponding training held in 6/97 and all follow ups focused on decision making related to risk vs. task completion.*	Bryan Martin Independent Death Review Panel 3/17/97
18. Investigation response	The Urgent Response Unit should be redesigned with staff specialized in qualifications and training.	**DSCYF response:** *This unit was unique to New Castle County and was disbanded, as it was not meeting expectations. More recently, a redesigned Urgent Unit was piloted in Sussex County with good success.*	Bryan Martin Independent Death Review Panel

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			3/17/97
19. Response to abuse calls	The Division must guarantee a full and appropriate response to all abuse calls.	**DSCYF response:** **In place** *Investigation protocol is required for all cases accepted for investigation.*	Bryan Martin Independent Death Review Panel 3/17/97
20. Length of investigation	The investigation standard of 45 days should be reduced to 15-20 days for the duration of the case.	**DSCYF response:** **In place** *Workers response requirements are as follows:* *URGENT- initial response within 24 hours; investigation concluded in 20* ***days although after initial assessment, a supervisor can change the priority to routine.*** *ROUTINE: initial response within 10 days and investigation completed within 45 days*	Bryan Martin Independent Death Review Panel 3/17/97
21. Investigation response	An urgent case should be treated as urgent until closed.	**DSCYF response:** **In place** *After initial contact and safety assessment, however, a supervisor may change the priority to routine*	Bryan Martin Independent Death Review Panel 3/17/97
22. Transfer of information	Coordinated case management among all who are involved in a central abuse component of successful identification of abuse	**DSCYF response:** **In place** *the person performing the after hours response must speak directly to the assigned investigation caseworker. This is tracked and monitored.*	Bryan Martin Independent Death Review Panel 3/17/97
23. Collateral contacts	As an ancillary recommendation, the Panel suggests that the investigation should also require at least one collateral contact (neighbor, family member, etc.) not provided by the suspected perpetrator.	**DSCYF response:** **In place** *caseworker to determine and select appropriate collateral contacts, alone or in consultation with the supervisor, based on allegations in the report and other factors learned about the family during investigation.*	Bryan Martin Independent Death Review Panel 3/17/97
24. Physical exam of children alleged to have been physically abused.	As part of the investigative process physical examination by a healthcare professional should be required in cases of reported abuse.	**DSCYF response:** **In place** *with supervisory discretion in some situations*	Bryan Martin Independent Death Review Panel 3/17/97

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DIVISION OF FAMILY SERVICES 16 Del.C. § 912 (b) (1)

OFFICE OF CHILDREN'S SERVICES

TREATMENT

1. Continued risk assessment during treatment.	DFS must establish a tracking mechanism and policy for treatment workers recording the contact schedule for children in the 0-6 age group to assess and assure their safety. These children must be seen on a regular basis.		CDNDSC Expedited Review, letter to the Governor 3/31/06.
2. Continued risk assessment during treatment.	Case plans and services should focus on the risk factors set out in the investigation risk assessment tool. While other issues crop up in these cases, resulting in additional or different services, workers must not lose sight of the issues that required initial DFS involvement.	**DSCYF response:** **In place**. *Policy specifies that part of the family assessment process includes reading the current investigation case as well as any DFS history. All of this information should be factored into the assessment, which in turn develops the Service Plan (case plan).*	CPAC near death report on John Davis, Jr. released 5/4/05
3. Continued risk assessment during treatment.	Risk assessment should continue to occur during the treatment process, and treatment workers should be thoroughly trained on same, including the protocol for serious injury reports.	**DSCYF response:** **In place** *Workers are expected to complete a Family Assessment and a Safety Assessment at the beginning of a case, whenever there is a significant change in the family (birth of a child, parent incarcerated, paramour moves into the home), prior to reunifying a child with their family, and prior to closing the case.*	CPAC near death report on John Davis, Jr. released 5/4/05
4. Sibling visitation	In one site, 57% of the foster care cases reviewed documented that there was no visitation among siblings or any indication that attempts were made to facilitate when siblings were placed separately.	**DSCYF response:** **In place** *Policy was revised to include the expectation that parent and sibling visits occur on a regular basis. In addition, when the Service Plan was reformatted in 2001, the visitation section contains specific information regarding sibling visitation, including frequency, duration, location, etc. Sibling visitation information is also now captured in the Plan for Child in Care series. In addition, the visitation schedule is now part of the court order. In FY06, the Division began contracting out with community-based agencies to specifically provide visitation services for children in care and their families. These contractors coordinate, transport and supervise visits. They also use the visitation time as an opportunity to provide instructional help.* *QA Case Review (Placement) tool reviews this issue. FY05 4th quarter results: Visitation between siblings- 88.89%.compliance.*	CFSR June 22, 2001
5. Parent/child visitation	In one of the sites reviewed, 80% of the foster care cases examined did not have visitation between the child and their parents and siblings	**DSCYF response:** **In place** *See above.*	CFSR June 22, 2001

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	occur as frequently as per policy or as arranged in the case plan	*QA Case Review (Placement) tool reviews this issue. FY05 4th quarter results: Visitation with parents- 93.33%.compliance.*	
6. Case closure with risk factors remaining Lacked clear safety goals	Cases lacked clear safety goals for open protective service cases, resulting in case closure before risk factors were resolved.	**DSCYF response:** **In place** *Case plan was reformatted in 2001. New format requires workers to select a specific goal for each identified problem area. In 2001, the Division of Family Services also began using the Family Assessment Form. The FAF scores families in 26 different areas and any area scoring at a designated level is automatically pulled into the Service Plan, thereby requiring the worker to address this issue with the family. At the time of case closure, workers are required to complete another FAF. In the closing FAF, areas that originally designated for the plan should be scoring better. If workers close a case without scores showing improvement, they must justify the closure.*	CFSR June 22, 2001
7. Appropriate services not provided	Over 25% of the cases reviewed had services that were identified as needed, but not provided.	**DSCYF response:** **In place**. *Continuum re-aligned to provide more units of services most in demand, eliminating waiting lists for any DFS Treatment program service.*	CFSR June 22, 2001
8. Case plan	While services may have been part of a case plan, the review did not find references to the outcomes of the services provided in some of the cases.	**DSCYF response:** **In place** *All DFS treatment contractors are required to submit regular (monthly) reports to the assigned DFS caseworker. In addition, prior to a provider closing a case, they must have a joint meeting between the DFS worker, the family and the contractor to discuss the identified areas of concern, the progress the family has made, any additional concerns, and any recommendations for future directions in the case. The contractor must also submit a written closing summary within two weeks of closing a case.*	CFSR June 22, 2001
9. Safety and treatment plans	Critical elements of safety and treatment plans should be strictly enforced. We know that not every element of every safety and treatment plan imposed by the Division is independently essential to the child's immediate safety. However, some elements, such as substance abuse evaluations and the exclusion of particular individuals from the household, are essential. Those critical elements of safety and treatment plans should be carefully monitored by the worker responsible for the case, and failure to comply with those critical elements should normally result in the removal of a child from a parent's home. If the Division is to follow this policy with respect to substance abuse evaluations and other elements of safety and treatment plans that it deems critical, it will need to develop a "tickler" system to remind case workers when these critical events are scheduled to have occurred.	**DSCYF response:** **In place** *Treatment workers must now complete a safety assessment at their first face-to-face contact within 7 days, prior to reunification, prior to case closure, and any other time there is a significant change – i.e. the birth of a child, paramour moves in. All safety assessments must be reviewed by supervisors. During recent safety assessment training, all workers were provided with descriptive elements for each of the safety influences. The treatment plan is now driven by the new Family Assessment Form.* *Safety Assessments are work listed in FACTS. This serves as a 'tickler' system and notifies workers of due dates for specific events. Safety Assessments must be reviewed by supervisors. In addition, in 2001, Directed Case Conferencing was implemented; supervisors complete these events during case conferences and risk factors such as substance abuse, domestic violence and mental health issues are reviewed and updated. Staff has received training on assessing safety elements and in safety planning. Since 2001, risk factors identified on the Family Assessment Form are automatically transferred to the treatment plan.*	Dejah Foraker Independent Death Review 1/8/99

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10. Cases monitored during worker's absence.	Cases must be monitored during workers' absences. The treatment worker who was responsible for Dejah's case during the last three weeks of Dejah's life was out of the office and out of contact with Ms. Foraker for that entire three week period, one week due to training and two weeks due to vacation. We were stunned by the fact that no provisions were made by the treatment worker and treatment supervisor to have someone cover this worker's cases during the worker's absence. This inexcusable neglect of Dejah's case is proof that the Division must develop formal procedures for the coverage of a worker's cases during extended absences from the office.	**DSCYF response:** **In place** *DFS has made timely and frequent contacts with families the top priority in ensuring safety for children. FACTS allows workers and supervisors to track contacts that are due and not completed. If a person is on extended leave, case responsibility is transferred. Where absences are frequent but unanticipated, FACTS allows DFS supervisors to track and assign contacts which are due.*	Dejah Foraker, Independent Review Panel Report 1/8/1999
11. Risks not addressed in the risk assessment tool therefore safety not assessed properly by treatment worker. Case plan not based upon risk factors.	Case plans developed for families should be consistent with the risks perceived by the worker investigating a case. Case plans should directly address risks to the child. Although DFS has a general policy regarding steps to be taken by treatment workers upon receipt of a case, and that policy includes a review of the investigation worker's conclusions, the policy does not emphasize the caution that should precede the preparation of a case plan that contradicts prior findings by the investigation worker.	**DSCYF response:** **In place** *Case plan was reformatted in 2001. New format requires workers to select a specific goal for each identified problem area. In 2001, the Division of Family Services also began using the Family Assessment Form. The FAF scores families in 26 different areas and any area scoring at a designated level is automatically pulled into the Service Plan, thereby requiring the worker to address this issue with the family. At the time of case closure, workers are required to complete another FAF. In the closing FAF, areas that originally designated for the plan should be scoring better. If workers close a case without scores showing improvement, they must justify the closure.*	Dejah Foraker, Independent Review Panel Report 1/8/1999

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FAMILY COURT 16 Del.C. § 912 (b) (1)			
1. History review by judicial officers	The courts should conduct a criminal background check and a review of custody, visitation, and PFA orders prior to modifying bail conditions	**FIRT Annual Report Actions Steps/Response:** When a party seeks to modify a condition of bail in Family Court, the court considers as a matter of course, the terms of existing Family Court orders and the criminal history of the party whose bail conditions are sought to be modified.	FIRT Annual Report July 2005
2. History review by judicial officers	In custody evaluation cases which occur as the result of a domestic violence murder/suicide, the Court should screen parties seeking custody for history of sexual assault and domestic violence.	**FIRT Annual Report Action Steps/Response:** In 2004, the General Assembly amended Section 722 of Title 13 directing the Family Court to consider "the criminal history of any party or any other resident of the house-hold including whether the criminal history contains please of Guilty of no contest or a conviction of a criminal offense" in determining the best interests of the child for purposes of deciding custody issues. Any history of sexual assault or domestic violence that rose to the level of a criminal action would be captured by this statutory consideration.	FIRT Annual Report July 2005
3. No clear policy/procedure for "at risk" children and their families and how to refer to DFS by Family Court.	Family Court and DFS should implement policies and procedures similar to those employed by law enforcement to ensure prompt and consistent notification to DFS of children seen by Family Court who are at-risk in intrafamilial relationships**.** While the Judiciary is designing a new computer system called COTS ("Courts Organized to serve"), there is an immediate need for DFS and Family Court to enter into discussions about how to achieve a better notification system regarding at-risk children seen by the Family Court but unknown to DFS. This should include a review of all matters brought before Family Court such as custody petitions, PFAs ("Protection from Abuse"), visitation matters and delinquency proceedings which should trigger notification to DFS and other child welfare systems	**DSCYF response:** **In place** If imminent risk, the report line should be called. DSCYF staff has participated in Family Court COTS meeting. Likewise, DSCYF will engage all key stakeholders, including the Courts, as we move to FACTS II.	CPAC near death report on John Davis, Jr. released 5/4/05
4. DFS not notified by Family Court	Family Court Commissioners and Judges, as statutorily mandated reporters, should notify DFS on all PFA petitions and "no contact orders" in which children are involved**.**	**DSCYF response:** **In place** If imminent risk, the report line should be called.	CPAC near death report on John Davis, Jr. released 5/4/05

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5. DFS not notified by Family Court.	Family Court and the Children's Dept. should develop a policy or procedure similar to the procedure between police and DFS regarding the referral of civil and criminal domestic violence incidents that result in Court orders where children are involved.	**DSCYF response:** **In place** If imminent risk, the report line should be called.	CPAC near death report on John Davis, Jr. released 5/4/05
6. History review by Judicial officers	All related files on a "family" should be presented to judicial officers when making civil determinations regarding children. Long term, the subcommittee recommends that this particular issue be incorporated into the new COTS computer system, enabling a full and complete picture of a family to be provided to the judicial officer to enable them to make the best possible decision on behalf of a child that first and foremost protects their safety.		CPAC near death report on John Davis, Jr. released 5/4/05
7. History review by Judicial officers	Delaware Code (Title 13, Ch.7, Subch. 2) states that in accordance with the best interests of the child, the criminal history of any party or resident of the household should be considered in custody proceedings. The Commission recommends that the Courts explore development of a process to ensure that Family Court Judges have access to all relevant civil and criminal records pertaining to all parties involved in civil custody cases.		CDNDSC Expedited Review, letter to the Governor 4/19/05.
8. Criminal History Review	The Child Death and Stillbirth Review Commission supports House Bill #78 (regarding use of DELJIS at Family Court).	**DSCYF response:** **In place** *H.B. 78 passed the General Assembly June 2004 and requires criminal history of any party and/or household members be considered in determining child's best interests.*	CDNDSC Expedited Review, letter to the Governor 7/3/03.
9. Domestic violence treatment	Require individuals with history or charge of domestic violence to go through domestic violence offender treatment.	**DSCYF response:** In place ***This is currently being ordered by the Court*** **DOJ response**: Individuals prosecuted for a domestic violence offense are routinely court ordered into certified batterer's treatment programs as per Court and DOJ rules and policies.	**CDNDSC** Annual Report 2002

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LAW ENFORCEMENT AGENCIES **16 Del.C. § 912 (b) (1)**			
1. Lack of trained police officers who specialize in investigating abuse/neglect	Wilmington Police Department (WPD) must have supervisors and officers who are fully trained in investigating child abuse/neglect cases and committed to working and communicating with all members of the child welfare system. If Wilmington Police Department is unable to investigate a child abuse and/or neglect matter, they should invoke 16 Del. C. § 906(b) (3), permitting the Delaware State Police to assist in such cases. This is critical not just for the intrafamilial cases where DFS is involved, but also for the countless City of Wilmington children subjected to extrafamilial abuse and/or neglect whose sole government agency protector is the WPD.		CPAC near death report on John Davis, Jr. released 5/4/05

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LEGAL/LEGISLATIVE			
16 Del.C. § 912 (b) (3)			
1. Statutory authority for CPAC to have subpoena power. Public distribution of reports based upon Federal CAPTA.	16 Del. C. § 912 should be modified to include statutory authority for CPAC to conduct future reviews of child welfare cases, including a provision for subpoena power in conducting reviews, and in cases of death or near death of the child, public distribution of any resulting reports.	**DSCYF response:** **In place:** CPAC supported giving *CDNDSC the statutory authority to conduct these reviews and CDNDSC shares findings and recommendations with CPAC*	CPAC near death report on John Davis, Jr. released 5/4/05
2. Public distribution of reports based upon Federal CAPTA.	Delaware law should be modified to comply with the CAPTA requirement for disclosure of findings and information in death and near death cases due to abuse and/or neglect, regardless of reviews	**DSCYF response:** **In place:** *see above* *CAPTA requires only annual reports summarizing activities, providing recommendations, including aggregate data on reports of abuse and disposition, deaths, families receiving services etc.* *The Keeping Children and Families Act of 2003 (P.L. 108-36 – formerly known as CAPTA) outlines a number of provisions, one of which is, "provisions of the findings or information about the case of child abuse or neglect which has resulted in a child fatality or near fatality". The Child Protection Accountability Commission (CPAC) has been designated the citizen review panel for Delaware and has plans to produce an annual report to include the near death reports. CPAC's annual report meets the intent and purpose of CAPTA provisions pertaining to public disclosure of child abuse or neglect which results in a child fatality or near fatality.*	CPAC near death report on John Davis, Jr. released 5/4/05
3. Increased prison time	Increasing prison time and scrutinizing plea agreements for abuse that results in the near death of a child should be explored. The plea agreement and jail sentence for this horrific crime committed against John Davis, Jr. was grossly insufficient. The punishment should fit the crime.		CPAC near death report on John Davis, Jr. released 5/4/05
4. Definitions of neglect	The statutory definitions of neglect should be reviewed and standardized, and should incorporate history as a basis for a finding of abuse or neglect. The current definitions and accompanying case law derived therefrom have cultivated incident-based findings that do not adequately consider the relevance of history in determining risk to children.	**DSCYF response:** **In process** *Legislative Subcommittee of CPAC has implemented this recommendation.*	CPAC near death report on John Davis, Jr. released 5/4/05
5. WPD needs to be	A representative of the Wilmington Police		CPAC near

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added to CPAC	Department needs to be added as a member of CPAC. The CPAC statute currently requires the appointment by the Governor of two law enforcement representatives. The New Castle County Police Department and the Delaware State Police have been critical participants in the Commission and this review. However, it is equally critical that a representative of the Wilmington Police Department be added to the Commission.		death report on John Davis, Jr. released 5/4/05
6. Hearsay exception	The hearsay exception (Title II, 2513) should be re-evaluated. The Commission suggests a collaborative effort to evaluate the statute among the Department of Justice, the Department of Services for Children, Youth, and Their Families, the Office of the Child Advocate, and an independent advocate for Children.	**DOJ response**: No longer constitutional under the Crawford decision.	CDNDSC Expedited Review, letter to the Governor 11/7/03.

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MEDICAL COMMUNITY **16 Del.C. § 912 (b) (1)**			
1. Child not followed after missed appointment.	CDNDSC will send a letter of concern to the Medical director of the child's clinic and/or hospital that clearly states that high risk moms and babies should have follow up mechanism in place so follow up is enacted when an appointment is not kept.		CDNDSC Expedited Review, letter to the Governor 3/31/06.
2. Proper protocol not followed	The CDNDSC will send a letter to the emergency room and radiology directors of Delaware hospitals requesting that they follow standards on how to properly examine a child for child abuse using skeletal surveys. The letter should specifically include a copy of the three year study from the American Academy of Pediatrics.		CDNDSC Expedited Review, letter to the Governor, 3/31/06
3. Public pool requirements	The Division of Public Health should review the public pool requirements and consider opportunities to reinforce appropriate signage requirements.		CDNDSC Expedited Review, letter to the Governor 7/3/03.
4. Adult supervision and responsibility	Periodically, there should be public notice to inform parents of their responsibility of supervising their children and the consequences of leaving them unattended. There should be seasonal public notification of the importance of adult supervision and water safety.	**DSCYF response:** **In process** *The Attorney General's office in collaboration with the Department of Services for Children, Youth and their Families and Department of Health and Social Services will draft the language of the notice.*	CDNDSC Expedited Review, letter to the Governor 7/3/03.
5. Screen for Domestic violence during well child visits	Require state funded medical insurance providers to routinely screen for domestic violence during well child visits, and encourage private insurers to accept the same standards.		CDNDSC Expedited Review letter to the Governor 10/24/02.
6. Hospital computer tracking system	The CDRC supports hospitals in developing some type of internal system that alerts physicians when a child's family has a history of violence and/or abuse.		CDNDSC Expedited Review letter to the Governor 10/24/02.
7. Referrals to	Make referrals to the appropriate medical/nursing	**CDNDSC Annual Report response:** *Follow through on this recommendation will be monitored*	CDNDSC

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licensing organizations	licensing organizations regarding a particular case if there is evidence that the standard of medical or nursing care may have been breeched.	*more closely once staff is hired by **CDNDSC**.*	Expedited Review letter to the Governor 10/24/02.

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Issue	Recommendation	Comments and/or follow up	Source

MULTI-DISCIPLINARY COORDINATION AND COLLOBORATION
16 Del.C. § 912 (b) (1) and (2)

1. Lack of multi-disciplinary collaboration and communication	DFS should develop a process to conduct interagency meetings, in particularly complex cases, including those cases of chronic neglect. This would enable all service providers to discuss the family's progress and identify any additional needs. This would apply to families that do not have Family Court oversight. At this meeting, case plans can be reviewed to assure services match the level of risk. As risk increases, so should the services to the family. If the family is uncooperative, the interagency meeting could decide if it best to terminate the services or file for custody of the child. 16 Del. C § 906 (b) (7)		CDNDSC Expedited Review, letter to the Governor 3/31/06.
2. MOU	All Law Enforcement agencies should, as part of their standard operating procedures, follow the Memorandum of Understanding (MOU) established among Law Enforcement, the Children's Department, and the Department of Justice.	**FIRT Annual Report Action Steps/Response**- New Castle County Police Dept. strongly supports the Domestic Violence FIRT Recommendations for Law Enforcement and will continue to follow the MOU established among Law Enforcement, the Children's Dept. and the DOJ. The Wilmington Police Department Victims Services Coordinator, Mona Bayard, is serving on the committee working to update the MOU. The Delaware State Police have and will continue to work within the guidelines established by the MOU adopted in 1989 and revised in 1998.	FIRT Annual Report July 2005
3. MOU	Immediately finalize the proposed updated MOU between law enforcement, DFS, the Children's Advocacy Center and the DOJ. This review and revision process should include how staff will work together in the field to address child welfare cases. If there are legal issues as to what information can and cannot be shared among these agencies, those issues should be clearly defined so that all of the partner agencies understand any limitations on information sharing.	**DOJ response:** Final revisions to the MOU have been made and will be mailed out for review and comment by member agencies in January 2006. **DSCYF response:** *DSCYF participates on MOU revision effort.*	CPAC near death report on John Davis, Jr. released 5/4/05
4. Lack of multi-disciplinary collaboration and	A process should be developed for interagency meetings to review and discuss particularly complex cases-- a system similar to the CAC's	**DSCYF response:** **In place; in process** *Departmental Policy, calls for multi-disciplinary collaboration and communication. The*	CPAC near death report on John Davis, Jr.

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communication	Case Review Team meetings, where agencies update each other on open and pending cases. This process must focus on the civil as well as the criminal components of the case. This process greatly minimizes the chances of cases falling through the cracks.	*Department took the lead in bringing the System of Care approach to Delaware. In Sussex County DSCYF holds monthly "System of Care staffings" in which workers refer cases to a team composed of representatives from all of the Department's service Divisions. In addition to Department representation, any agency or individual with knowledge or involvement with the case is invited to attend as well. The focus of this committee is to ensure that the needs of all of the family members are being addressed. Similar staffings have begun in Kent County and ongoing training in System of Care.* *There is a High Risk Infant Protocol in the DSCYF-DPH MOU which requires a pre discharge meeting for approach should lead to similar approaches among all disciplines involved agencies for high risk infants.* **DOE response:** "Lack of multi-disciplinary collaboration and communication" is cited repeatedly throughout the recommendations. In this case, a process for interagency meetings is identified. Schools would welcome this. Unaware of any activity relative to this.	released 5/4/05
5. Lack of multi-disciplinary collaboration and communication	Multidisciplinary protocols must be established to address breakdowns in intra-agency and interagency communication. Front line personnel should be made aware of liaisons, contacts, etc. in their own agency and in other agencies that can facilitate communication breakdowns.	**DSCYF response:** **In place MOU** *with other agencies outline communication and contact protocols.* **DOE response:** Again, here is a reference to "lack of multi-disciplinary collaboration and communication". In this case, protocols are recommended to assure frontline personnel are of liaisons, MOUS. This would be important for schools. Unaware of situations where this applies to schools or any activity relative to this.	CPAC near death report on John Davis, Jr. released 5/4/05
6. Lack of collateral contact with medical experts regarding abuse/neglect.	Law Enforcement as well as other disciplines should consult with child abuse/neglect medical experts when investigating a possible child abuse/neglect case.		CPAC near death report on John Davis, Jr. released 5/4/05
7. Lack of multi-disciplinary collaboration and communication	The Commission supports the Children's Dept. in its leadership role to develop and implement a system of care for children and families in Delaware. In particular, the Commission recognizes the value of information sharing and enhanced communication within and between public agencies serving the State's children.	**DSCYF response:** **In place** *see above Department appreciates support for SOC.* **DOE response:** *Again, here is a reference to "Lack of multi-disciplinary collaboration and communication". This case was a school-age child.* THE SYSTEM OF CARE INITIATIVE SHOULD ADDRESS THIS ISSUE.	CDNDSC Expedited Review, letter to the Governor 4/04/05.
8. Lack of multi-disciplinary collaboration and	Additional means of communication needs to be developed to provide law enforcement with information regarding complaints received by	**DSCYF response:** **In place; in process** *In an effort to improve services to children and families guidelines for and establish collaboration and communication, DSCYF, Delaware Police Dept's, and the Dept. of*	FIRT Annual Report 2003

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communication	DFS and to include victim services information in the loop.	*Justice created an MOU. The AIC is currently working on collaboration and communication, DSCYF, Delaware Police Dept's, and the Dept. of Justice created an MOU. The AIC is currently working on revising the MOU.*	
9. MOU	Review the Memorandum of Understanding among the Department of Justice, the Department of Services for Children, Youth, and Their Families, and the Delaware Police agencies for clarification of roles, and for the addition of the Children's Advocacy Center of Delaware, Inc. and the medical community.	**DSCYF response:** **In place; in process** *See above*	CDNDSC Expedited Review, letter to the Governor 10/24/02.
10. Lack of multi-disciplinary collaboration and communication	Review coordination and communication between Investigative Officials (police, medical examiner, social services)	**DSCYF response:** **In place; in process** *See above*	CDNDSC Annual Report 2001
11. Lack of multi-disciplinary collaboration and communication	A lack of provider reports to case workers and a lack of coordination and communication between the agency and service providers were pointed out in the review.	**DSCYF response:** **In place** *Contracts with service agencies have reporting and communication requirements.*	CFSR June 22, 2001
12. Lack of multi-disciplinary collaboration and communication	The Division must interact more regularly with law enforcement on related cases. In cases where a parent or caretaker has been charged with a crime as a result of the same act that resulted in DFS involvement, DFS must work more closely with law enforcement and prosecutors to monitor the progress of parallel criminal investigations. These criminal investigations can uncover critical facts regarding the family, or in some cases actually result in incarceration of the parent, which can have obvious consequences for the child.	**DSCYF response:** **In place; in process** *See two items above*	Dejah Foraker Independent Review Panel 1/8/1999
13. Lack of multi-disciplinary collaboration and communication	DFS and Delaware's law enforcement agencies should implement formal procedures to improve their collaboration in child abuse investigations. These procedures should provide for full sharing of information and evidence, and prompt notification of decisions.	**DSCYF response:** **In place; in process** *See items above*	Tytyana Kennedy Independent Death Review 4/22/98
14. Lack of multi-disciplinary collaboration and communication	DFS and Delaware's law enforcement agencies should be required to prepare a written action plan at the outset of each joint investigation describing each agency's short-term	**DSCYF response:** **In place; in process** *See items above*	Tytyana Kennedy Independent Death Review

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	responsibilities.		4/22/98

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Multi-Disciplinary Reporting and Investigation of Child Abuse and Neglect 16 Del.C. § 912 (b) (2)

1. New incident of abuse/neglect logged as a progress note vs. a hotline.	DFS should review compliance with current DFS policies regarding new allegations of abuse and/or neglect in a case already open for DFS investigations or treatment. It is once again recommended, that when new allegations of abuse and/or neglect are called in to the child abuse report line, that a new hotline report be written. This will ensure that all available history presented to DFS will be available to the future possible worker.		CDNDSC Expedited Review, letter to the Governor 3/31/06.
2. Mandatory reporters not calling the DFS hotline.	DFS should stop accepting written police bin reports in lieu of statutorily mandated oral reports. All reports of suspected child abuse and neglect are required to be made orally to DFS pursuant to Title 16 Del. C. § 904. The Memorandum of Understanding between DFS, Police, and the Attorney General's Office provides additional guidance to law enforcement officers on how to make a report of suspected child abuse and neglect.		CDNDSC Expedited Review, letter to the Governor 3/31/06.
3. Mandatory reporters not calling the DFS hotline.	Law Enforcement Agencies should make immediate notification to the Division of Family Services in domestic violence fatality cases where the parties have minor children.	**FIRT Annual Report Action steps/Response**-The Delaware State police officers make immediate notification to the Division of Family Services in domestic violence fatality cases where the parties have minor children. It has been the policy of New Castle County Police Department to immediately notify the Division of Family Services whenever minor children are involved in Domestic Violence cases, whether minor or fatal in nature. The City of Wilmington (Wilmington Police Dept), as per Directive 6.19 Section I.C4. (2003); Whenever a child is injured or put in danger as a result of a domestic violence complaint, it shall be the responsibility of the officer (s) investigating the complaint to contact the on-call worker at Division of Family Services immediately and advise them of the situation. It shall be documented in the officer (s) report, whether the on-call worker responded and what action was taken.	FIRT Annual Report July 2005
4. MOU compliance Mandatory reporting	WPD should review Title 16, Ch. 9 and the Memorandum of Understanding, to ensure compliance by all of its employees, including but not limited to using the proper domestic violence		CPAC near death report on John Davis, Jr. released 5/4/05

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	incident reports, and keeping DFS regularly apprised of the status and findings of its investigation. 16 Del. C. § 906(b) (4).		
5. Hotlines not accepting cases despite risk factors	DFS should review its research on nationwide risk assessments and consider modifying or replacing its current structured decision-making tool at the hotline and during the investigation process. In the short term, protocols for acceptance of a case by the report line should be reviewed and improved to consider history. Specifically, a compilation of risk factors such as low birth weight, previous DFS history, HIV positive, drug positive at birth, fetal alcohol syndrome, criminal history etc., should trigger an automatic acceptance of a case. Such tools and protocols will help to standardize DFS responses to reports of child abuse and/or neglect.	**DSCYF response:** **In place** *The agency was a leader amongst child welfare agencies in implementing a structured approach to safety assessment and safety planning. Our current decision-making tool considers such factors as previous DFS history, alcohol and drug abuse, criminal history and other danger-level elements. However, each factor alone does not warrant automatic acceptance as a report. (For example, there are many reasons why a baby may be low birth weight. Being HIV positive does not automatically mean the individual is a poor parent.) The tool is designed to assist staff in assessing the level of risk. However, no structured tool can replace experience and sound critical thinking and development regarding child welfare policy, procedure, and client-staff interaction.*	CPAC near death report on John Davis, Jr. released 5/4/05
6. Mandatory reporters not calling the DFS hotline.	Training regarding the reporting of abuse and neglect as required by 16 Del. C. § 911 (a) and (b) should be implemented, with an annual training schedule being developed and widely distributed to the broader child welfare community and the public. Wide publication of the child abuse report line to the public and child welfare professionals should occur immediately as required by 16 Del. C. § 911(c).	**DOE Response:** *This case dealt with an infant, but the recommendation can be applied throughout all systems. Education personnel do receive annual training, which is required by law; however, those who provide contracted services, volunteers and students are not included in the training.* ALL PUBLIC SCHOOLS PROVIDE AN ANNUAL, MANDATED TRAINING ON CHILD ABUSE IDENTIFICATION AND REPORTING. **DOJ response:** The AG's Abuse Intervention Committee has formed subcommittees to focus on 2 primary report sources: education and the medical community. **DSCYF response:** **In place**. *DFS has a speaker's bureau, trains school teachers, and has memoranda of understanding with many agencies. We routinely teach at the police academies.*	CPAC near death report on John Davis, Jr. released 5/4/05
7. Mandatory reporters not calling the DFS hotline.	The Wilmington Police Department, Family Court and the local hospitals should ensure that their employees are aware of the mandatory reporting laws for suspected child abuse and/or neglect and the penalties for failure to report. 16 Del. C. §§ 903 and 914. With respect to the Wilmington Police Department, they should also review and ensure employee compliance with the reporting requirements under the Memorandum of Understanding between Law Enforcement, the DSCYF and the Department of Justice ("MOU").		CPAC near death report on John Davis, Jr. released 5/4/05

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8. Hotline not reviewing other adults in the home and their history.	DFS should take steps to ensure that hotline and investigative staff request complete information on all parents, parties, and members of the child's household, and that FACTS checks on those individuals are completed and the results clearly conveyed to others within the Division, as required by 16 Del. C. § 905(d).	**DSCYF response:** **In place** *Policy requires FACTS history checks for family members. Information is documented in the record. Individual performance is managed through structured performance review process and, as needed, around particular events.*	CPAC near death report on John Davis, Jr. released 5/4/05
9. Hotlines not accepting cases despite risk factors and report made by professional.	The Division of Public Health should document problems they encounter with clients and meet periodically with DFS to get clarification on what to report to the hotline and the best way to report concerns to DFS.	**DSCYF response:** **In place** *DFS has two staff collocated with Child Development Watch. We have an MOU with DPH that specifies reporting requirements.*	CPAC near death report on John Davis, Jr. released 5/4/05
10. Hotlines not accepting cases despite risk factors and report made by professional.	Reports made by professionals should be given the highest degree of deference and accepted in all cases unless good cause exists for rejecting the report. Reporters should be contacted immediately by the investigation worker (16 Del. C. § 906(b) (13)) and provided with the outcome of the decision and/or the investigation. 16 Del. C. § 906(b) (16).	**DSCYF response:** **In place** *Current policy states that "The Division of Family Services will give special consideration to information provided by individuals outside the family network especially from other professionals and from persons in regular contact with the child."* *16 Del. C. § 906(b) (13)) requires that when a written report is made the reporter be contacted within 48 hours. DFS policy states the reporter shall be contacted within 24 hours.* *16 Del. C. § 906(b) (16)) says if requested the reporter shall be given information about the disposition of the report at the conclusion of the investigation. We give the reporter information about the disposition of the report (accept/reject) within 24 hours. The disposition of the investigation is confidential information.*	CPAC near death report on John Davis, Jr. released 5/4/05
11. High Risk Infant Protocol not followed	In conjunction with giving the highest degree of deference to reports made by professionals, including the Division of Public Health, the High Risk Infant Protocol should be reviewed, and all parties should make a renewed commitment to its use to ensure the safety of high risk newborns.	**DSCYF response:** **In place** *The Division has met with the participating agencies of the High Risk Infant Protocol to discuss adherence issues and will continue to meet at least yearly.*	CPAC near death report on John Davis, Jr. released 5/4/05

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12. Hotlines not accepting cases despite risk factors	DFS should automatically accept for investigation all hotline reports on a newborn when a parent has lost custody of previous children due to abuse and/or neglect even without a new allegation of abuse or neglect so as to give the new baby the same protections that the other children have received.	**DSCYF response:** **In place** *DFS investigates reports of alleged abuse and neglect of children, or* ***risk of abuse or neglect. Previous history with the agency would be considered in deciding whether to accept the referral for investigation.***	CPAC near death report on John Davis, Jr. released 5/4/05
13. New incident of abuse/neglect logged as a progress note vs. a hotline.	The Commission recommends that DFS review compliance with its current policy regarding new allegations of abuse and/or neglect in a case already opened for treatment or investigation. It is recommended that when new allegations of abuse and/or neglect are called in to the Child Abuse Report Line, that a Hotline Report be written. This will ensure that child safety is fully addressed	**DSCYF response:** **In place** *Current policy requires a new report to be written regarding a new allegation of abuse or neglect. If the case is active in Investigation, the issues in the new report must be addressed. If the case is active in Treatment, the case will be assigned to an Investigation worker.*	CDNDSC Expedited Review, letter to the Governor 4/19/05.
14. New incident of abuse/neglect logged as a progress note vs. a hotline.	Case reviews documented concerns regarding incidents occurring in open cases that should have been, but were not, processed as reports of abuse and/or neglect	**DSCYF response:** **In place** *This finding was based on one incident in one case. Policy and procedures are in place to investigate new incidents.*	CFSR June 22, 2001
15. New incident of abuse/neglect logged as a progress note vs. a hotline.	Evidence of multiple reports, some with the same perpetrator and some reports for the same reasons, occurred without appropriate responses by the Department to ensure that safety of the children was documented in some cases	**DSCYF response:** **In place** *Case history has been emphasized to be considered in assessment of risk. See previous and later related items*	CFSR June 22, 2001
16. Multi-Disciplinary communication	Report all cases of drowning to the DFS Child Abuse Report Line by police or first responders.	**DSCYF response:** **In place** *The Memorandum of Understanding shared by Law Enforcement and DSCYF allows consideration of circumstances before reporting.*	CDNDSC Annual Report 2000

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17. Hotlines not accepting cases despite risk factors and report made by professional.	The panel found that one of the most striking deficiencies in the Division's response to the allegations raised in this case was that abuse complaints by legally mandated abuse reporters appeared to be accorded no greater weight than those made by more involved parties who may have personal or even improper motivations	**DSCYF response:** **In place** *Current policy states that "The Division of Family Services will give special consideration to information provided by individuals outside the family network especially from other professionals and from persons in regular contact with the child."*	Bryan Martin Independent Review Panel 3/17/1997
18. New incident of abuse/neglect logged as a progress note vs. a hotline.	The Division should implement procedures to ensure that reports of categorically different abuse in open cases go to the hot line.	**DSCYF response:** **In place** *see earlier item. In addition, an objective investigation worker investigates all new reports, even on active treatment cases.*	Bryan Martin Independent Review Panel 3/17/1997
19. Knowledge of mandatory reporting and signs of abuse/neglect	Increase awareness by primary care and emergency room health care professionals of the physical signs of child abuse and neglect.	**DSCYF response:** **In place** *The Division of Family Services collaborated with the publishers of the Medical Society Journal to devote one issue specific to child abuse. The agency also trained medical personnel on the signs of abuse and neglect.* **DOJ Response:** The AG's Abuse Intervention Committee has formed subcommittees to focus on 2 primary report sources: education and the medical community.	Bryan Martin Independent Review Panel 3/17/1997

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MULTI-DISCIPLINARY TRAINING
16 Del.C. § 912 (b) (4)

Issue	Recommendation	Comments and/or follow up	Source
1. Lack of knowledge of "best practices" regarding investigation and treatment of abuse/neglect.	All CPAC members should make a renewed commitment to pooled resources and training to ensure annual comprehensive, multi-disciplinary training on child abuse and/or neglect. Training should use the recommendations in this report and specifically focus on the various components of the child welfare system and how critical multi-disciplinary collaboration is to ensuring the safety of children. Immediate training issues shall include: a. Reporting of child abuse and/or neglect; b. Detecting child abuse and/or neglect; c. DFS hotline responses to reports of child abuse and/or neglect; d. Communication between DOJ, law enforcement, and DFS on the civil and criminal aspects of a case, and the inclusion of Family Court for communication regarding policies and procedures; e. Child welfare and domestic violence; f. Importance of child welfare history; and g. Investigative techniques to address cases where there is more than one suspected perpetrator.	**DOE response:** *Schools provide mandatory training aimed at educators. We have not systematically provided training to our health personnel, i.e. school nurses and counselors, related to many of these issues.* ALL PUBLIC SCHOOLS PROVIDE AN ANNUAL, MANDATED TRAINING ON CHILD ABUSE IDENTIFICATION AND REPORTING. THE STATE HAS SPONSORED A CONFERENCE ON DOMESTIC VIOLENCE. THE SCHOOL NURSING: TECHNICAL ASSISTANCE MANUAL (REVISED 2005) NOW INCLUDES INFORMATION ON DOMESTICE VIOLENCE AND REFERRAL CONTACTS. **DOJ response:** The American Prosecutor's Research Institute developed Finding Words. This training is considered best practice and will be offered in Delaware throughout 2006 with plans for future trainings. **DSCYF response:** **In place** *Abuse Intervention Subcommittee of CPAC created to pool resources, identify trainings. Committee surveyed the community re: child abuse and neglect and provided priority training requested by responders (2005). Previously, committee sponsored conferences with child abuse and neglect themes.*	CPAC near death report on John Davis, Jr. released 5/4/05
2. Lack of	Expand education and training on child abuse,	**DSCYF response:**	CDNDSC

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knowledge of "best practices" regarding investigation and treatment of abuse/neglect including domestic violence	child neglect and domestic violence to health care providers.	**In place** *See above* The AG's Abuse Intervention Committee has formed subcommittees to focus on 2 primary report sources: education and the medical community.	Expedited Review letter to the Governor 10/24/02.
3. Lack of multi-disciplinary collaboration and communication	Ensure compliance with 16 Del.C. Section 906 (b) (3) through training and supervision of all appropriate personnel in the child welfare community.	**DSCYF response:** **In place** *See above*	CDRC Expedited Review, letter to the Governor 10/24/02.
4. Lack of knowledge of "best practices" regarding investigation and treatment of abuse/neglect.	DFS caseworkers and police officers should receive better training in child abuse investigations.	**DOJ response:** The American Prosecutor's Research Institute developed Finding Words. This training is considered best practice and will be offered in Delaware throughout 2006 with plans for future trainings. **DSCYF response:** **In place** *In addition to improvement in training for all new staff, DFS has taken advantage of joint training opportunities.*	Tytyana Kennedy Independent Review Panel 4/22/1998

Issue	Recommendation	Comments and/or follow up	Source

MULTI-DISCIPLINARY USE OF CHILD WELFARE HISTORY IN DECISION MAKING 16 Del.C. § 912 (b) (1) and (2)

1. History not being utilized appropriately to assess risk to a child.	DFS should review current policy and practices regarding how case histories are reviewed and incorporated into decision making and develop a standardized protocol regarding how case histories are used.		CDNDSC Expedited Review, letter to the Governor 3/31/06.
2. History not being utilized appropriately to assess risk to a child.	DFS should create a data management and retrieval system that would allow DFS staff to view history in a timeline or summary format.		CDNDSC Expedited Review, letter to the Governor 3/31/06.
3. History not being utilized appropriately to assess risk to a child.	DFS must once again re-evaluate the adequacy of its training regarding the use of history in making decisions on removal and placement of children. This case should be used in future trainings. Quality control measures should be used to ensure that history is being taken into consideration in all casework.	**DSCYF response:** **In place** *DFS provides extensive training in using history while making case decisions: in new worker training and in focused refresher trainings (as recently as 2004 and- 2005)* *Workers receive training about DELJIS, FACTS and CYCIS.* *An historical search is to be conducted to determine if the family has been active in the Department/Division of Family Services in the past and to identify a pattern of child maltreatment or violence. Information collected from these sources will be used in screening and in assigning a response time, in assessing risk and for case planning.* *DFS accepts and investigates cases based on risk. Child risk assessments consider history as a factor in removal decisions.The Directed Case Conference (DCC) provides supervisors with standard questions to ask during routine case conferences. The DCC must be completed at least quarterly. Questions focus on on-going contact with the family, changes in household composition, safety planning, and progress on the case plan.* *Investigation staff assess for birth to age 3 developmental needs and the other CFSR well-being needs such as education and medical. Investigation assists with limited services such as food and*	CPAC near death report on John Davis, Jr. released 5/4/05

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		clothing closets, emergency shelter, and protective day care.DFS specifically trains that abuse findings do not depend upon charging decisions or legal classifications of conduct. *Internal and external agency partners are invited and have attended new worker and refresher trainings that focused on the importance of history.*	
4. Lack of clear guidelines/policy on how to utilize history when assessing safety.	DFS must evaluate its policies to clarify *how* history should be used by caseworkers.	**DSCYF response:** **In place** *See above*	CPAC near death report on John Davis, Jr. released 5/4/05
5. History not being utilized appropriately to assess risk to a child.	DFS caseworkers should be trained that history, especially abuse history, does not depend upon charging decisions or legal classifications of conduct.	**DSCYF response:** **In place** *See above*	CPAC near death report on John Davis, Jr. released 5/4/05
6. History not being utilized appropriately to assess risk to a child.	The importance of history should be incorporated into multi-disciplinary child welfare training.	**DSCYF response:** **In place** *See above*	CPAC near death report on John Davis, Jr. released 5/4/05
7. History not being utilized appropriately to assess risk to a child.	DFS continues to operate an "incident based" belief system for removal of a child from his or her home. Documented patterns of abuse or neglect may warrant removal even in the absence of a single serious incident".	**DSCYF response:** **In place** *See above*	CPAC near death report on John Davis, Jr. released 5/4/05
8. Criminal History not being utilized appropriately to assess risk to a child.	Incorporate into the current system a flag for workers to check DELJIS as part of their case work. To the extent workers do not have DELJIS access, access must be expanded. It is disturbing to hear that treatment worker #2 did not know whether or not she even had access to DELJIS to check the history of their clients. DELJIS information is critical in making safety and treatment decisions regarding children.	**DSCYF response:** **In place** *See above*	CPAC near death report on John Davis, Jr. released 5/4/05
9. Criminal History not being utilized appropriately to assess risk to a child.	Pursue development of policy and procedure that would enable appropriate and necessary utilization of Deljis and premise history by Division of Family Services' workers.	**DSCYF response:** **In place** *See above*	CDNDSC Expedited Review, letter to the Governor 10/24/02.
10. Criminal History not being utilized	DFS should have access to criminal information so they can review the criminal history of	**DSCYF response:** **In place** *See above*	FIRT report 2001

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appropriately to assess risk to a child.	families under investigation, this is critical to their ability to prioritize and respond to complaints received.		
11. History not being utilized for proper family assessment of needs.	The review indicated that case histories and current information were not always considered when assessing needs of the families and identifying services to address family issues	**DSCYF response:** **In place** *See above*	CFSR June 22, 2001
12. History not being utilized appropriately to assess risk to a child.	Workers should be trained in the gathering of available information about families they are investigating or treating. Workers' training should clearly indicate what family information is available to workers and what information they should routinely obtain in the performance of their duties. Workers should also be trained to obtain all available information about families from other agencies and entities while investigating a case.	**DSCYF response:** **In place** *See above*	Dejah Foraker, Independent Review Panel Report 1/8/1999
13. History not being utilized appropriately to assess risk to a child.	The Division should require complete access to all information among the different Division offices in investigations. Staff should be mandated to retrieve information from all sources before determining how to proceed in a case. The important point here is that these employees did not believe that they were entitled to review the child care licensing records in depth and that, other than being aware of the existence of investigations and their disposition, there appears to have been little opportunity for staff to see a full overview of the case across components and time.	**DSCYF response:** **In place** *See above*	Bryan Martin Independent Death Review Panel 3/17/1997

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OFFICE OF THE ATTORNEY GENERAL
16 Del.C. § 912 (b) (1)

1. Case not prosecuted.	Implement a Department of Justice case tracking system to ensure that cases do not fall through the cracks when personnel are reassigned from their unit or charges are filed at different levels. This system should apply to both the civil and criminal Divisions of DOJ and be fully accessible by both.	**DOJ Response**: The DOJ has received FY 06 funding from the General Assembly to conduct an IT Needs Assessment. The DOJ IT group will contract for this service.	CPAC near death report on John Davis, Jr. released 5/4/05
2. DFS worker not notified of case outcome	Criminal case outcomes involving child victims or an open DFS case should be transmitted to DFS workers. This may require some type of liaison to assist in tracking such cases and facilitating communication between DOJ, DFS, law enforcement, Children's Advocacy Center and Family Court.	**DOJ Response:** • The DOJ IT group has been working to develop an automated notification system for partners since 1999. There have been unexpected delays and problems with this program. Victim Service staff at the DOJ provide manual updates on flagged cases. • The Criminal Division has received approval to create a Child Abuse and Neglect DAG position through the Bryne Grant. This position will be responsible for prosecuting all felony level child abuse cases in NCC and will be responsible for coordinating misdemeanor cases between the Criminal and Civil Divisions. A tracking system will be developed and will be made available to the Civil DAG's. • A request has been made for Deljis to create a required field for police officers to identify a case as being a child abuse or neglect case. This would be similar to how cases are identified as DV. **DSCYF response:** **In place** *If imminent risk, call the report line.*	CPAC near death report on John Davis, Jr. released 5/4/05
3. Lack of multi-disciplinary collaboration and communication	DOJ should review 16 Del. C., Ch. 9, and the 1998 Memorandum of Understanding requiring multi-disciplinary collaboration between state agencies involved in child protection and apply those principles to the DOJ internally.	**DOJ response:** Completed	CPAC near death report on John Davis, Jr. released 5/4/05

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March 17, 1997 to May 5, 2006

Issue	Recommendation	Comments and/or follow up	Source

WELL-BEING
16 Del.C. § 912 (b) (5)
ADOPTION

No documented public recommendations at this time.

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WELL-BEING
16 Del.C. § 912 (b) (5)
CHILD CARE

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WELL-BEING
16 Del.C. § 912 (b) (5)
EDUCATION

1. Education records were not gathered for intact homes.	Educational information was generally not gathered for the in-home child protective service cases evaluated by one of the review teams unless education was singled out as a significant issue. Serious educational needs were not assessed or addressed in some of the cases evaluated.	**DSCYF response:** In place ***Educational needs are now assessed on every child residing in their own home through the use of the SENSS.*** **DOE Response:** *In this case, school records were NOT gathered. The schools did not prevent or impede the review. SYSTEMS ARE IN PLACE FOR SCHOOLS TO SHARE RECORDS WITHIN THE PARAMETERS OF THE LAW. SCHOOLS HAVE HISTORICALLY COMPLIED WITH REQUESTS FOR RECORDS INFORMATION RELATIVE TO CHILD ABUSE, NEGLECT, AND DEATH.*	CFSR June 22, 2001
2. Students and DV	Domestic Violence Coordinating Council (DVCC) should meet with the Secretary of Education to discuss the critical role of schools in responding to children whose parents are in violent relationships. Plans should be made to provide in service training for teachers, possibly using DVCC Law Enforcement Training funds or collaborate with DFS.	**DSCYF response:** **In place** *DSCYF currently fulfills its responsibility to provide annual in-service education to all teachers on child abuse. Information regarding domestic violence has been a component of that training and we will continue to collaborate with DVCC.* **DOE response:** *Schools provide mandatory training aimed at educators. We have not systematically provided training to our health personnel, i.e. school nurses and counselors, related to many of these issues.* ALL PUBLIC SCHOOLS PROVIDE AN ANNUAL, MANDATED TRAINING ON CHILD ABUSE IDENTIFICATION AND REPORTING. THE STATE HAS SPONSORED A CONFERENCE ON DOMESTIC VIOLENCE. THE SCHOOL NURSING: TECHNICAL ASSISTANCE MANUAL (REVISED 2005) NOW INCLUDES INFORMATION ON DOMESTICE VIOLENCE AND REFERRAL CONTACTS. Information for students and families relative to domestic violence is needed. Unaware of activities directed towards students/families relative to domestic violence.	FIRT Annual Report 2001
3. Students and DV	Information should be provided to schools to assist them in establishing polices for responding when students disclose that their parents are in a violent relationship.	**DOE response:** See Response to recommendation #1 above.	FIRT Annual Report 2001

WELL-BEING
16 Del.C. § 912 (b) (5)
Foster Care

Issue	Recommendation	Comments and/or follow up	Source
1. Background history of future guardian from another state not thoroughly researched.	Even though item 6a of regulation # 3 of the Interstate Compact regulations exist, if a Delaware State agency is involved in any way, that agency should assure that the receiving guardian is not listed on the child protection registry or any other relevant registry. At the next national meeting at which the compact agreement is discussed, representatives from Delaware should state that Delaware agencies have adopted this suggestion as best practice and recommend that other states in the compact do the same.	**DSCYF response:** In place; in process ***This recommendation came from a review not involving placement in foster care. State concerns on the need to reform Interstate Compact for the Placement of Children (ICPC) have been conveyed through the American Public Human Services Association, which convened the ICPC Task Force in July 2004 . ICPC is being reviewed and revised. Delaware is an active participant.***	CDNDSC Expedited Review, letter to the Governor 11/7/03.
2. Lack of monitoring when child was sent to another state through ICPC.	Resources should be allocated for the interstate compact with respect to the juvenile justice system to better monitor children moving between jurisdictions.	**DSCYF response:** **In place** *Resources for the ICPC were secured through the budget process.*	CDNDSC 2002 Annual Report
3. Foster family not informed of child's issues.	Cases showed that important issues for the foster family to know about, such as substance abuse, past sexual abuse and grief/loss issues, were not identified	**DSCYF response:** **In place** - *Prior to placement Safety Assessment implemented to ensure a child would be appropriate and safe in foster home with current mix of children. Foster parents are now seen within five days after child has been placed. Effective 8/04- Medical Transfer Instruction Sheet is completed and follows every child. Foster parent bi-annual survey measures adequacy of information received.* *Foster parent **receives** a placement packet upon placement of any **child. Included** in this packet is the child's level of care.*	CFSR June 22, 2001

Issue	Recommendation	Comments and/or follow up	Source

WELL-BEING
16 Del.C. § 912 (b) (5)
INDEPENDENT LIVING

No documented public recommendations at this time.

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WELL-BEING **16 Del.C. § 912 (b) (5)** **MENTAL HEALTH SERVICES**			
1. Lack of services and/or treatment for children who have witnessed homicide/suicide.	If the Victim Crimes Compensation Board does not currently do so, it is recommended that they provide funding for counseling services for children of perpetrators in domestic violence homicide cases	**FIRT Annual Report Action Steps/Response:** As contained in Title II Chapter 90 § 9020 of the Delaware Code; (a) The costs of psychological assessment done for the purposes of evaluating the mental health needs of a child victim may be paid from the Victim's Compensation Fund and (b) The costs of short term counseling, as defined by the Board, for the purposes of meeting the mental health needs of a child victim may be paid for the Victim's Compensation Fund.	FIRT Annual Report July 2005
2. Lack of services and/or treatment for children who have witnessed homicide/suicide.	OCA should monitor the provision of mental health evaluation and treatment services for child witnesses to homicide and suicide.	***DOJ response****: Not under the statutory mandate for OCA but is for CPAC Federal and State laws re: confidentiality may prevent this monitoring from occurring. Mental health services are generally voluntary not mandatory and families can arrange for services privately and may not have an interest in ongoing government involvement.* **DSCYF response:** **In place** DCMHS Crisis Intervention Service is available for youth/families experiencing a mental health crisis. **In addition, DCMHS is providing training for the City of Wilmington's Police Department on the crisis intervention service; and we've secured a competitive grant to help deliver services to children who have witnessed violence and/or who have been traumatized by exposure to violence.**	FIRT Annual Report 2003.
3. Lack of continued mental health services upon discharge from Ferris.	Establish a mechanism to implement Child Mental Health Services upon discharge from Ferris; that would also address continuity in care for mental health needs for children discharged from Ferris.	**DSCYF response:** **In place** As part of the Department's long-range strategy, mental health services for youth in YRS residential services are now administered by sister Division DCMHS to further integrate services and enhance mental health services for youth in DYRS. Discharge plans for youth with mental health issues who are to be released from Ferris will include community-based services for mental health treatment wherever appropriate. **DOE response:** This recommendation could impact schools if the child is transferring from Ferris to a public school. Unaware of any activity relative to this.	CDNDSC Annual Report 2002

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WELL-BEING **16 Del.C. § 912 (b) (5)** **REHABILITATION**			
1. YRS risk assessment tools do not adequately evaluate risk.	Re-evaluation of risk assessment system to be developed for the Children's Department to reliably inform case managers of percent of risk when case is transferred within the Juvenile probationary system.	**DSCYF response:** In place ***DCMHS and DYRS collaborated to review instruments and implementation processes. Currently in use are the SENSS (departmental risk assessment tool), MAYSI and the PESQ (both are used broadly across the nation with the juvenile justice population). As well as the RAI. These in addition to the ERS and the CAS reviews as needed. Implementation review continues.***	CDNDSC 2002 Annual Report
2. Dangers of firearm usage not always a part of discussion with families when interacting with DYRS.	DSCYF staff should discuss dangers of firearms and other risk factors in the home that can affect safety of a child.	**DSCYF response:** **In place** *High risk juveniles are required to participate in Gun and Violence awareness initiatives in partnership with the US attorney's office, DOC and others. DYRS is seeking appropriate literature to share with youth in detention and/or at initial intake for probation.*	CDNDSC Annual Report 2002
3. Lack of continued mental health services upon discharge from Ferris.	Have children who are going back into school from legal trouble assigned a counselor (mentor) such as an Intervention Specialist	**DSCYF response:** **In place** *DOE is working with the Children's Department to provide "wrap around services", I.e. Behavioral Support Services, to children who have been involved with Foster Care or any Delaware Mental Health Services.*	CDNDSC 2000 Annual Report

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WELL-BEING **16 Del.C. § 912 (b) (5)** **SUBSTANCE ABUSE**			
1. AOD evaluations.	Completion of evaluations before returning a child to home. In situations like Dejah Foraker's where a child's safety is jeopardized by the substance-influenced behavior of the child's caretaker and a substance abuse evaluation is therefore ordered, the evaluation in question should be completed and analyzed before the child is returned to the caretaker. The Division's failure to follow this seemingly self-evident procedure in Dejah's case, and its failure to remedy the problem by leaving Dejah in Ms. Foraker's home even after Ms. Foraker failed to go to her evaluation, was the most egregious breakdown in this case. If DFS needs to obtain the capacity to perform in-house substance abuse evaluations in order to comply with this recommendation, it should do so.	**DSCYF response:** **In place** *Substance abuse liaisons are collocated in regional offices are offer support services for obtaining evaluations and referrals to treatment programs.* *Revised child safety model requires a thorough safety evaluation to be completed prior to the return of the child.* *In situations where parental substance abuse is known, policy requires substance abuse evaluations to be completed prior to the return home of a child and if the parent is in treatment, a favorable report from the treatment agency as well as a significant time in recovery.* *DFS has a MOU with the Division of Substance Abuse and Mental Health which provides monthly progress reports.*	Dejah Foraker, Independent Review Panel Report 1/8/1999

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WELL-BEING
16 Del.C. § 912 (b) (5)
VICTIM SERVICES

1. Child died and there was significant DV in the home.	The CDRC is also interested in exploring collaboration with the DVCC in reviewing child abuse deaths and promulgating system change when the child's death was not the direct result of domestic violence, but a significant domestic violence component was present in the family.	**CDNDSC Annual Report***: Dialogue between the DVCC and* ***CDNDSC*** *will need to occur once staff is hired by the* ***CDNDSC****.*	CDNDSC Expedited Review, letter to the Governor 10/24/02.
2. An increase of children exposed to DV.	There is a need for increased services for children living in violent homes. Children should be made aware that there are people they can talk to about the abuse they are witnessing in their homes and that they are not the only ones living with that problem.	**DSCYF response:** **In place** *In January 2001, a new interagency Children and DV work group was created to develop recommendations for meeting the needs of children in violent homes.*	FIRT Annual Report 2001.